

Foreign Animal Disease (FAD) or Emerging Disease Incident (EDI) Initial Investigation Reporting Form

Submitted by	Review Cycle
Natalie	
Jones/MD/APHIS/USDA	
on 09/12/2000 at 03:14 PM	




Investigation Information

Complaint

Referral Control Number	Investigation Date: 09/12/2000
Assignment Date: 09/12/2000	Investigation Time: 03:22 PM
Quarantine Date:	Local ID Number:

Investigator:	Investigator Phones & FAX:
Status:	Reason:
<input checked="" type="radio"/> Open <input type="radio"/> Pending Lab Results <input type="radio"/> Pending Final Diagnosis <input type="radio"/> Closed	
Priority:	Reason:
<input checked="" type="radio"/> None <input type="radio"/> One <input type="radio"/> Two <input type="radio"/> Three	
Case Def:	
<input type="radio"/> Pos <input checked="" type="radio"/> Neg	



Owner Information / Comments

Animal Owner Information	
Name:	Phones: & FAX:
Address:	Type of Operation: 
City:	State:  NA
County: 	Zip:
Latitude:	Longitude:

Comments about Owner and/or Directions or Map to Location:


Initial Referring Contact	Type
Name:	Phones & FAX:
Comments:	

Animal Location and Premises Owner (If different than Animal Owner Information)

Animal	Location
Premises Owner:	Phone Home & Work:
Address:	City:
County: 	Latitude:
	Cell & FAX:
	State:  NA
	Longitude:

Comments about Animals or Animal Location and/or Directions or Map:

Animal Information / History

Animal	Information
Identification: 	Date of onset of condition :
	Date of first death :
	Total animals on premises :
	0
	Primary Species
	Second Susceptible Species
	Other Susceptible Species

Number Sick :	
Number Dead :	
Total number of species:	







History and Examination Results

History [Help!]
Description:




Physical Exam [Help!]																																																
<table> <tr> <th></th> <th>Normal?</th> <th></th> <th>Comments</th> </tr> <tr> <td>General [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Skin [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Head Area [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Respiratory [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Cardiovascular [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Abdomen-Digestive [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Urogenital [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Musculoskeletal [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Nervous [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Lymph Nodes [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> <tr> <td>Other [?]</td> <td><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam</td> <td></td> <td></td> </tr> </table>		Normal?		Comments	General [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Skin [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Head Area [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Respiratory [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Cardiovascular [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Abdomen-Digestive [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Urogenital [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Musculoskeletal [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Nervous [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Lymph Nodes [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam			Other [?]	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> No Exam		
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Lab Information

Lab Information [Help!]															
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Comments on Lab Samples:

Diagnostic Information								
<table> <tr> <td>Differential Diagnosis</td> <td></td> <td>Field Evaluation</td> <td></td> </tr> <tr> <td>Most probable diagnoses & other comments: <small>(Put most probable from above list first then other comments)</small></td> <td></td> <td></td> <td></td> </tr> </table>	Differential Diagnosis		Field Evaluation		Most probable diagnoses & other comments: <small>(Put most probable from above list first then other comments)</small>			
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